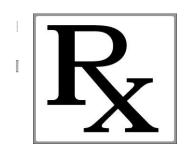


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## **Durable Medical Equipment**

## FAX TO: (719) 638-4080

## 5145 N. Academy Blvd. Suite#210 Colorado Springs, CO 80918

	PATIENT	Γ INFORMATIO	N:			
PATIENT NAME:		DOI	3:/_	/	ORI	DER DATE:/
ADDRESS:		CITY:			STATE	E/ZIP:
PHONE:						
		MEMBER ID:				
STANDARD ELECTRIC BREA	 ST PUMP (F0603)	DX: Z39	.1			
	pump (E0604) Length			D	X:	
(2 TUBING, 2 CAPS, 2 BO		VALVES/MEI	/IBRANES	, MILK	BAGS)	
Post-partum garment (					-	DX: M62.08
Compression socks (A6						DX: R60.9
Pelvic support brace (L06		Size: XS SN				DX: R10.2
Prenatal Cradle (V-sling	) (L8310) QTY: Si	ze: XS SM	M L	XL		DX: O22.00
C- Section Kits	(QTY A6212 QT)	Y A52	245)			DX: O90.0
Other: Please specify:			DX:			
I certify that I am the physicia medical necessity information						•
documentation to help with		•		-	_	
them for any additional infor	mation to process this orde	er. A copy o	f this ord	der wil	l be retai	ned as a part of the
patient's medical record.						
	REQUESTING PH	YSICIAN INI	ORMAT	ION		
Physicians Name:			NPI: _			
Signature:						<i></i>
Contact Phone:						
		tv.			-	7in·